Developmental Disabilities

Residential Study Advisory Council

DEVELOPMENTAL DISABILITIES RESIDENTIAL STUDY

REPORT

JANUARY 2006

Submitted to Governor Christine Gregoire and the 2006 Legislature

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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The Legislature authorized the Developmental Disabilities Residential Study and the formation of an Advisory Council with the adoption of the state's 2005-2007 operating budget. The purpose of the study is to identify a preferred system of residential services for individuals with developmental disabilities and a plan to implement the system within four years.

Study Overview

In September of 2005 Governor Gregoire appointed nine members of the Advisory Council to represent the interests of families, consumers, community providers, advocacy, labor, and government entities. In addition to the Governor's nine appointments to the Council, the Legislature's President of the Senate and Speaker of the House each appointed two legislative members.

The Council met monthly in October, November, and December 2005. The focus of the first three meetings was to gather information and data. The Council reviewed background information on eligibility, services, community residential programs, state residential habilitation centers (RHCs), projected capital needs, and cost comparisons between community residential and RHC programs.

A portion of each meeting was set aside for public comment, and members of the audience were invited to submit written comments for inclusion in the meeting notes. Meeting notes and presentations are posted on the Study's website: http://www.governor.wa.gov/disabilities/default.htm.

The Governor's Council representative indicated that the State is at a "fork in the road" with regard to making decisions about the extent to which residential services for individuals with developmental disabilities will be provided in traditional large, congregated settings. Deferred

maintenance and projected capital facility improvements cannot be put off much longer. On the other hand, many families raising children with developmental disabilities have come to experience a different set of expectations for service delivery. Some families, however, want to have the choice of a full range of options, including RHCs.

Residential Services

The Division of Developmental Disabilities (DDD) provides residential services in institutional care settings and in community-based settings. DDD manages five residential habilitation centers (state institutions) and contracts with private providers for an array of community-based programs, such as supported living, adult family homes, and group homes. The FY 04 operating budget for residential habilitation centers (RHCs) was $153 million, serving 1033 clients. The FY04 operating budget for adult community-based residential services was $245 million, serving 5,634 clients.

Projected RHC Capital Needs

Every two years the Department of Social and Health Services (DSHS) prepares a Ten-Year Capital Plan that is submitted to the Office of Financial Management. Projected capital requirements for 2007-2017 include requests for health, safety, code and regulatory compliance, such as the waste water treatment plant at Rainier School and storm water and sewer improvements at Lakeland Village; building and infrastructure preservation, such as maintenance building upgrades at Fircrest School and roof repairs at Lakeland Village; and facility improvements and upgrades, such as a new maintenance building at Yakima Valley School and cottage renovations at Fircrest, Morgan Center, Lakeland Village, and Rainier School. Projected capital requirements for 2007-2017 total $65,000,000.

Cost Comparisons for RHCs and Community Residential

Cost comparisons between community-based settings and RHCs are very difficult to make. Client needs are the biggest driver of cost, regardless of setting. Clients with high needs and high service costs are served in both RHCs and the community. Many clients have services that cost less or more than the average. Staff costs are the largest component of the total rate, and pay and benefit rates are higher for staff at the RHCs. On average, community-based residential settings cost less than RHC services. For FY 04, the average cost for community-based settings was calculated at $345/day in total funds, or $153/day in state funds. For FY 04, the average cost for all RHCs was calculated at $401/day or $189/day in state funds.

Recommendation

The Council completed the initial phase of data and information gathering, but did not have time to begin the solutions phase of the Study. Although no conclusions or decisions were made in the limited time that was available, the Council informally agreed to recommend that the Developmental Disabilities Residential Study should be extended into 2006 and resume meeting in April 2006 to complete the study and work of identifying a preferred system of residential services.

PART I: STUDY OVERVIEW

INTRODUCTION

The 2005 Legislature appropriated funds for an Advisory Council to study residential services for persons with developmental disabilities. The purpose of the study is to identify a preferred system of residential services for individuals with developmental disabilities and a plan to implement the system within four years, including recommendations that best address client needs in different regions of the state.

The 2005 Budget Proviso went into effect July 2005. In September 2005 Governor Christine Gregoire announced the appointment of nine members to the Advisory Council representing the Office of Financial Management (OFM), the Department of Social and Health Services (DSHS), the Washington State Developmental Disabilities Council, two labor organizations, the community residential care providers, residents of residential habilitation programs, individuals served by community residential programs, and individuals with developmental disabilities who reside or resided in residential habilitation centers. In addition to the Governor's nine appointments to the Council, the Legislature's President of the Senate and Speaker of the House each appointed two legislative members representing their majority and minority caucuses. Staff from OFM, DSHS, the Developmental Disabilities Council, the House of Representatives, and the Senate provided support to the Council. (See Appendix for list of Council members and staff.)

At the initial meeting of the Advisory Council, the Governor's representative indicated that the objectives of the Study included gathering the best available information for the Council to prepare a plan; creating a common understanding of the impacts, including fiscal, of the proposed solutions; and involving the public in an open and objective way. It was noted that the State is at a "fork in the road" with regard to making decisions about the extent to which residential services for individuals with developmental disabilities will be provided in traditional large, congregated settings. Deferred maintenance, and projected capital facility improvements cannot be put off much longer. On the other hand, many families raising children with developmental disabilities have come to experience a different set of expectations for service delivery. They want supports that enable them to keep their family members at home and to be part of their local community. Some families, however, want to have the choice of a full range of options, including RHCs. In addition, pressures from people who are under-served and un-served have created a critical need for addressing a long-range plan for services in the future.

BACKGROUND

In 2003, the Legislature directed the Department of Social and Health Services to downsize the population of Fircrest School, a Residential Habilitation Center (RHC), by closing cottages and consolidating vacancies across all five Residential Habilitation Centers– Fircrest School in Seattle; Rainier School in Buckley; Yakima Valley School in Selah; Lakeland Village near Spokane; and Frances Haddon Morgan Center in

Bremerton. By June 30, 2005, a total of 84 people had moved to other RHCs, various community residential options, or nursing homes.

In Governor Locke's final proposed budget, he suggested closing Fircrest School. However, as an alternative to closure, Governor Gregoire and the Legislature formed the Residential Study Advisory Council to offer stakeholders and interested parties another opportunity to publicly debate the issues and hear the concerns of all involved.

ACTIVITIES TO DATE

The Council met three times between October and December of 2005. Meeting agendas consisted of presentations of information and data from the Division of Developmental Disabilities and other sources, Council discussion, and public comment. Given the large amount of background material, staff presentations, and time allocated for public comment, Council total discussion time was somewhat limited. A summary of the meeting schedule and agenda topics is as follows:

- October 20, 2005
  Framework of the Project
  Introduction to DDD and Residential Services
  Historical Context, Studies, Legislation, and Budget Actions
  Work Plan Discussion
- November 18, 2005
  Medicaid Basics
  Assessing Eligibility for Residential Services
  Current Residential Services for People with Developmental Disabilities: Descriptions and Costs
  Facilitated Brainstorming Exercise
- December 15, 2005
  RHC Capital Needs
  FY 04 Cost Comparison Summary of Community/RHCs
  Emerging Issues
  Facilitated Brainstorming Exercise

In addition to the time provided for public comment, the audience was encouraged to submit written remarks for inclusion in the meeting notes, which along with the presentation materials, are posted on the Residential Study's website: http://www.governor.wa.gov/disabilities/default.htm.

At the conclusion of the meetings, some members of the audience provided written handouts for Council members in additions to written comments for the meeting notes. These documents are not part of the electronic record on the website. However, copies may be obtained by contacting OFM, (360) 902-4111.

PART II: DDD RESIDENTIAL SERVICES

Below is a summary of the presentations made to the Council during the three meetings. Complete notes may be accessed on the website noted above.

Determination of Eligible Disability

Publicly funded services are provided through the Department of Social and Health Services via the Aging and Disability Services Administration (ADSA)/Division of Developmental Disabilities (DDD). Eligibility is determined by DDD. Washington State's definition of developmental disability includes certain conditions that begin before the age of eighteen:

- Mental Retardation
- Developmental delay, ages birth to nine
- Cerebral palsy
- Epilepsy
- Autism
- Or, another neurological or other condition found by the DSHS Secretary to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

Neither financial nor service needs are considered when making the determination for eligibility to be an enrolled client of the Division of Developmental Disabilities.

Eligibility for Services

Eligibility for DDD services is a 3-step process. An individual must be determined to have a developmental disability as defined above; be assessed as needing services, and meet other eligibility requirements and/or financial eligibility requirements, such as, Medicaid income and asset limitations. Being determined eligible for DDD services does not create an entitlement for DDD services.

DDD Services

DDD, in cooperation with community partners, provides an array of services to eligible clients:

- Case management
- Early childhood intervention
- Respite care
- Personal care
- Professional services, e.g., health services and therapies
- Residential Habilitation Center services (state institutions) and State Operated Living Alternatives (SOLA)
- Community Residential Services (provided through contracts with private entities.)
- Employment and day services (provided through contracts with county government.)

Contracted service providers provide the majority of residential services and personal care in the community. State employees provide services in RHCs and SOLA programs.

DDD Medicaid Services

Medicaid is a means-tested, federal-state program that funds health and long-term-care services for individuals who meet certain income and eligibility criteria. Within federal law, states have some flexibility to design their own programs, including eligibility, reimbursement rates, benefits, and service delivery. States that participate in Medicaid must cover certain eligibility groups and a set of mandatory services. The federal government provides matching funds to states for the costs of covering eligible individuals. In Washington, the typical match is $1 of federal for every $1 of state funding.

In addition to mandatory Medicaid services, such as medical care, states may offer "optional" Medicaid services in their state plan. Washington has chosen to provide Medicaid Personal Care (MPC) and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) as part of its "regular" Medicaid program. If an individual meets eligibility criteria, access to these MPC and ICF/MR services is considered an "entitlement". Washington's waiver-based program provides a Medicaid alternative to institutionalization and is also an "optional" program for eligible clients; however waiver services are not an entitlement.

Medicaid Personal Care

Medicaid Personal Care provides assistance with activities of daily living, such as bathing, eating, and dressing, to Medicaid eligible individuals. Services are provided in the person's home by an individual or homecare agency provider, or in certain community residential settings, such as adult family homes or adult residential care facilities. Functional eligibility is assessed with the CARE assessment tool. To be eligible, a person must require substantial assistance with at least one, or minimal assistance with more than two, direct personal care tasks.

Medicaid ICF/MR and Nursing Facility Services

In Washington, the vast majority of ICF/MR services are provided in the RHCs. RHCs may be certified as an ICF/MR or a skilled nursing facility, or both. ICF/MR services are available on a 24-hour basis and include medical and nursing services, physical and occupational therapy, recreational services, and room and board. Federal ICF/MR standards require that each resident receive a continuous "active treatment" program that includes training and treatment to improve and maintain independent functioning. The CARE Assessment determines functional eligibility.

Medicaid Home and Community-Based Waivers

Home and community-based service waiver programs provide a Medicaid alternative to long-term care in institutions. States have greater flexibility to manage home and community-based waiver programs and access to the waiver program is not an entitlement. Waiver programs vary by state, but typically include services not offered on the Medicaid State Plan, such as, supported employment, mental health stabilization, respite care, and community residential supports. Waivers can have enrollment caps. In addition, waiver programs enable states to control utilization and costs in ways not permitted under the "regular" Medicaid program.

DDD operates four Home and Community-Based Waiver Programs: Basic, Basic Plus, Core, and Community Protection. Each of these waiver programs has an established enrollment cap. (See the DSHS/DDD website for additional details.)

DDD Budget Snapshot for 2005-07

- Biennial Operating Budget:
  Total funds: $1.4 billion, $770 million General Fund-State (GF-S)
  9.7 % of all DSHS GF-S expenditures/3,320 FTEs

- Biennial Capital Budget
  $8.8 million in state funds and bonds for capital improvement to RHCs

DDD Residential Services

For the purposes of data presented to the Council, "residential services" referred to paid, out-of-home services funded by DDD. This definition did not include individuals with developmental disabilities who reside with their parents or other family members.

Only a subset of people with developmental disabilities receive paid residential services. Based on FY 04 DSHS-RDA Client Service Data Base, approximately 32,000 clients are enrolled in DDD. Of that number, approximately 20,000 clients receive paid DDD services, including 13,000 who live at home with families or relatives. Approximately 7,000 clients receive paid out-of-home residential services, not including adults with developmental disabilities in nursing homes paid for by Long-Term Care. DDD residential services are provided in either "institutional" or "community-based settings".

Institutional Care Settings

DSHS considers Residential Habilitation Centers and private nursing facilities to be institutional care settings for residential services. In FY 04, on average, 21% of adults with developmental disabilities receiving paid out of home residential services resided in institutional settings.

The majority of institutional services are provided in the RHCs. DDD operates five RHCs, staffed by state employees, which may be certified either as a skilled nursing

facility, an ICF/MR, or both. RHCs provide 24-hour/7 day per week supervision and specialized habilitative programming. Admission to an RHC requires an assessment to ensure that the client is Medicaid eligible and in need of "active treatment" services. Residents of RHCs may not be moved to community programs without the consent of their legal guardian. 86% of the current RHC residents have lived in an RHC continuously for over ten years. 60% have lived in an RHC continuously for over 30 years. Most residents are adults—in FY 04 fewer than 2% of RHC residents were under the age of 23. All RHCs provide some respite or crisis beds based on availability, but only Yakima Valley receives dedicated funding for 16 respite beds. RHCs vary in size from 50 to 400 clients.

FY 04 RHC Population and Operating Budget				
RHC	**Average # of Residents**	**% Total RHC Population**	**Budget (all funds)**	**% Total RHC Budget**
Fircrest	243	24%	$39 million	26%
Frances Haddon Morgan	53	5%	$ 8 million	5%
Lakeland	248	24%	$36 million	23%
Rainier	383	37%	$ 53 million	35%
Yakima Valley	106	10%	$16 million	11%
Total	**1,033**	**100%**	**$152 million**	**100%**

On average, in FY 04, 1,033 people resided in RHCs, or 14% of adults with developmental disabilities receiving paid out of home residential services (including private nursing facilities). The total (state and federal) cost in FY 04 for RHCs was $152 million, or 36% of the funds spent on out-of-home residential services.

As of July 2005, approximately 472 adults with developmental disabilities were served statewide in private sector nursing facilities, or 7% of adults with developmental disabilities receiving paid out of home residential services. The total (state and federal) cost to provide these services is estimated at $19 million for FY 04, or 5% of the funds spent on out-of-home residential services. (These services are not paid from the DDD budget, but are part of the larger ADSA or long-term care budget.)

Community-Based Settings

Community-based residential services include both facility and non-facility based settings. In FY 04, on average, 79% of adults with developmental disabilities receiving paid out of home residential services resided in community-based settings. See the table below with budget and population information followed by descriptions of the settings that are currently provided in Washington State.

FY 04 Community-Based Adult Residential Population and Operating Budget				
	Average # of Clients	**% Total Community Residential**	**Budget (all funds)**	**% Total Community Residential Budget**
Supported Living	3,411	61%	$187 million	76%
SOLA	113	2%	$12 million	5%
Adult Family Home	1,395	25%	$22 million	9%
Group Home	392	7%	$16 million	6%
ARC or Boarding Home	241	4%	$3 million	1%
Community ICF/MR	58	1%	$4 million	2%
Companion Homes	24	<1%	$1 million	<1%
Total	**5,634**	**100%**	**$245 million**	**100%**

- **Supported Living**—non-facility based instruction and staff support provided to clients who either live alone or share living expenses with others in the community, typically in apartments or rental homes. Supports are provided by private agencies or individual providers and may vary from a few hours per month to 24/7 staffing. SOLA clients are supported by state employees rather than contracted providers. Households may consist of 1 to 4 people.

- **Adult Family Homes (AFH)**—facility-based, licensed, and privately operated. AFHs provide 24/7 supervision and personal care support. Client needs vary and can include clients with more complex needs, including medical. These facilities are primarily used for long-term care, with training required to serve clients with developmental disabilities. Setting may not be licensed for more than 6 people.

- **DDD Group Homes**—also facility-based and licensed for 24/7 supervision, specifically for persons with developmental disabilities. Group homes are certified to provide training in addition to personal care support. They were originally licensed to house up to 20 clients; however, the average size is now about 8 clients.

- **Adult Residential Care (ARC) or Boarding Homes**—facility-based, licensed and privately operated. Resident needs may range from light care to intermittent nursing services. These facilities are primarily used for long-term care. Current settings range from 12 to over 100 residents.

- **Community ICF/MRs**—similar in size to group homes, community ICF/MR facilities provide 24/7 supervision, habilitation training, and specialized medical and nursing care. Clients must meet Medicaid eligibility and be in need of active treatment services provided. Current settings range from 5 to 14 residents.

- **Companion Homes—**non-facility based supports provided in an adult "foster care model". Limited to one client per home, companion homes assure client health, safety, and well being 24/7 in a "regular" family residence approved by DDD.

- **Children's Foster Care**—Foster family services are long-term placements requested by families with children with developmental disabilities. Licensed, individual foster families provide most services in their own homes, although some children receive services in contracted group homes. 307 children were served by DDD foster care in FY 2004.

HISTORICAL OVERVIEW, KEY STUDIES AND REPORTS

Like other states, Washington began to move from an institutional model of services to a community model in the late 1960s. The establishment of the Medicaid program and changes at the state level regarding public education created new opportunities for individuals with developmental disabilities. Legislation continued to be enacted during the 1970s that provided greater civil rights; and amendments to the Medicaid program made federal funding available for services to be provided in the community. The shift at both the state and national level towards de-institutionalization can be observed by the declining population at RHCs. In 1967 there were over 4,000 RHC residents and in 2004, there was an average of 1,033.

The issue of institutional and community-based residential services has been the subject of numerous studies and reports. (See the website for the following studies posted in their entirety.) They include but are not limited to:

Residential Services for Persons with Developmental Disabilities--Legislative Budget Committee (1991-1993): an evaluation of state-operated and community-operated residential services comparing costs in various developmental disability (DD) residential settings.

Recommendation 1: Legislation should be enacted in the 1993 session that provides policy direction on the role of DD community services and state institutions.

Recommendation 2: DSHS should develop a management plan that includes a specific operational plan to develop more cost-effective DD services that reach a larger population than currently served.

Recommendation 3: The Legislature should consider providing more flexibility in DD funding that reduces or eliminates the distinction between institutional and community service funds, including a more neutral budget approach to downsizing.

Developmental Disabilities Strategies for the Future Stakeholders Workgroup (1997-2002): development of a long-term strategic plan and determination of how services should be provided to people with developmental disabilities.

Phase 1: Recommended an increase in the DDD budget of $148 million ($88.9 million state)

Phase 2: Reached a consensus on using choice and self-determination as the foundation for restructuring supports and services.

Phase 3: Recommended the following:

- Stabilize the developmental disabilities system
- Implement system changes that encourage self-directed services
- Enact legislation that includes the following concepts:
  - A need-based continuum of supports for families to allow persons with developmental disabilities to live at home
  - A choice-based safety net of residential options for children and adults whose needs are of such intensity that they cannot be cared for in the home
  - A recognition that when the family caregiver reaches age 60 or beyond there should be an alternate residential option available
- Use the stakeholders' work on "the Future of the RHCs" as the basis for future use of RHCs.

Capital Study of the DDD Residential Facilities Joint Legislative Audit and Review Committee (JLARC) (2002): a study of the possible alternative uses of the land and facilities currently used by state operated RHCs.

Recommendation 1: The State should develop options to dispose of excess property at Lakeland Village, Rainier School, and Yakima Valley School.

Recommendation 2: DSHS should provide a report to the Legislature addressing projected future institutional needs; anticipated changes in the type of care needed by residents, and alternative or combined use scenarios for each campus.

Planning for the Future of the Residential Habilitation Centers (2003): DSHS's response to the JLARC Capital Study with discussion of three future options for the RHCs.

Option 1: Reduce current RHC capacity

Option 2: Complete closure of the RHCs

Option 3: Continue the current policy direction where some RHCs remain open, but with regularly funded downsizing and some admission capacity, until attrition and downsizing force additional consolidation and closure.

CAPITAL BUDGET

Like other state agencies that run facilities, DDD has a need for investments in repairs, remodels, and maintenance of its facilities, as well as the need for long-term planning about programs and infrastructure. DDD's five RHCs need periodic capital investments

to maintain health, safety, code & regulatory compliance; building & infrastructure preservation; and facility improvements & upgrades.

Community-based residential settings are not part of the state's capital budget, which does not pay to construct or maintain community settings. Therefore, any capital costs for community providers show up only in the operating budget, through the rates paid to providers.

Capital Budgeting Process

Like the operating budget, the capital budget is a limited resource, and all of state government competes for funding. State bonds finance most capital projects. Borrowing is limited by statute and by the state constitution. The process works as follows:

- Each state agency proposes a ten year capital plan. DSHS must develop a plan that balances the various needs for developmental disabilities, mental health, juvenile rehabilitation, and special commitment.
- All state agencies' ten year capital plans are considered by the Governor, who then proposes a ten year plan for all of state government (K-12 education, higher education, human services, natural resources, etc.)
- The Legislature proposes its own ten year capital plan. A 60% legislative majority is required to pass a bond bill to finance the approved projects.

Projected Capital Requirements for 2007-2017

The table below outlines the next ten years of estimated capital projects to maintain current capacity at all five RHCs, make improvements, and maintain health and safety requirements. The capital needs proposed total $65 million. (For more detail, see Council Presentation: "RHC Current Uses and Future Capital Needs".) Due to competing requests and limited capital funds, it is likely that only a portion of these items would actually be funded by the Legislature.

RHC	Summary of 2007-2017 Capital Requirements	Estimated Expenditures
Fircrest	Steam line repairs, electrical distribution upgrades, building abatement & demolition, kitchen & laundry equipment replacement, equipment upgrades, building remodels, and cottage renovation	$ 20,000,000
F.H. Morgan Center	Storm sewer improvements, roof replacement, repairs & exterior painting, kitchen refrigeration units replacement, HVAC upgrades, other preservation projects, office remodel, and cottage renovation	6,000,000
Lakeland Village	Building and roof repairs, storm water and sewer improvements, fire protection upgrades, sidewalk & paving repairs, irrigation improvements, other preservation projects, and cottage renovation	14,000,000
Rainier	Waste water treatment plant compliance, electrical	22,000,000

RHC	Summary of 2007-2017 Capital Requirements	Estimated Expenditures
	improvements, water mains upgrades, storm water & sewer upgrades, environmental compliance, steam distribution system improvements, roofing repairs & replacement, HVAC upgrades, kitchen upgrades, paving repairs & upgrades, other preservation projects, renovation of cottages and administration building	
Yakima Valley	HVAC cleaning & balancing, paving repairs & upgrades, other preservation projects, bathing system upgrades, new maintenance building	3,000,000
Total		$65,000,000

RHC/COMMUNITY COST COMPARISONS

Cost comparisons between community-based settings and RHCs are difficult, for a number of reasons. The Council requested that staff come up with as close of a comparison as possible. The Office of Financial Management, Legislative, and DSHS fiscal staff worked together to determine a cost comparison that the three staffs could agree upon. When viewing cost comparisons, the following information should be kept in mind:

- Client needs are the biggest driver of costs, regardless of care setting. For example: clients in supported living have varying service needs, which drive the number of hours of service, which drives cost. A client with high support needs in an institution is likely to also have high support needs in the community.
- Cost comparisons reflect average costs. Many clients cost less or more than the average cost.
- Clients with high needs and high service costs are served both in the community and in RHCs. Some clients served in RHCs have services that cost less than those served in the community and vice versa.
- Staff costs are the largest component of total costs. Both pay rates and staffing levels determine staff costs. Pay and benefit rates are higher in RHCs.

Methodology:

Staff to the Council did a comparison of average costs that would potentially be the most useful in planning future placements. Staff based the community costs on the amount the Legislature budgeted in FY 04 to add new community residential services for priority populations, such as people in crisis, and people wishing to move from RHCs to the community. Through the budget, the Legislature requires that the total cost for the priority population be no more than $300/day on average. (If *all* current community-based residential services were examined, and not just the placements for priority populations, the average cost would be somewhat lower.)

Also, staff endeavored to make the total costs for both community-based settings and RHC as complete and as comparable as possible. To do this, staff followed the lead set

by the Joint Legislative Audit and Review Committee 2003 Performance Audit of DDD, which noted that additional benefits outside of DDD are used to supplement residential services. For example, staff added the estimated DSHS costs for medical assistance and mental health to the $300/day budgeted for DDD, making the "service package" for community-based settings more comparable to the RHC setting.

Data for the comparison comes from two sources: DSHS and Legislative budget for FY 2004. RHC costs are based on the expenditures reported to the federal government by DSHS. Community-based costs are based on the average budgeted amount provided for priority placements for new residential services, and DSHS data on the average cost to provide medical assistance and mental health to persons with disabilities.

Results

See the table and notes below. This table in larger print size, along with other detailed staff notes on cost, are available in the appendix and on the website (see "FY 04 Cost Comparison Summary for Developmental Disabilities Residential Services").

The conclusion of this comparison is that on average, community-based residential settings cost less than RHC services. For FY 04, the average cost for community-based settings was calculated at $345/day in total funds, or $153/day in state funds. For FY 04, the average cost for all RHCs was calculated at $401/day or $189/day in state funds. Average costs for each individual RHC vary, and can be seen on the table in the appendix.

FY 04 Cost Comparison Summary for Developmental Disabilities Residential Services

Office of Financial Management, Legislative, and DSHS Fiscal Staff Estimates

Community-Based, Budgeted Rate FY 2004 Budget Proviso Level and Estimated Actuals	Daily Costs Total	 State
Residential and Support Services	$ 300	$ 141
Priority Placements (paid through DDD)		
Est. Medical Assistance (paid through MAA)	$ 21	$ 10
Est. Mental Health (paid through MHD)	$ 5	$ 2
Est. Room and Board (SSI, Client Funds)	$ 19	$ -
Total	**$ 345**	**$ 153**
Annual Total	**$ 126,000**	**$ 56,000**

Residential Habilitation Center FY 2004 Average Actual	Daily Costs Total	 State
Operating Costs (Includes IMR tax)	$ 402	$ 189
Less IMR tax	$ (20)	$ (9)
Indirect Costs	$ 21	$ 10
Accrued Vacation Liability	$ (0)	$ (0)
Equipment Depreciation	$ 1	$ 0
Building Depreciation	$ 15	$ 7
Non-Capitalized Bldg Expenditures	$ 0	$ 0
Bond Interest for Bldg	$ 5	$ 2
Less Unallowable Costs	$ (4)	$ (2)
Total	**$ 419**	**$ 197**
Less Client Participation (SSA)	$ (18)	$ (8)
Adjusted Total	**$ 401**	**$ 189**
Annual	**$ 147,000**	**$ 69,000**

Both Service Costs Include:
*Residential supports, which could include 24/7 available supervision.
*Habilitative programming.
*Employment and day.
*Medical, mental health, and therapies (except off-campus hospitalization and some equipment for RHC clients).
*Room and board. (In community-based, room and board is paid with federal SSI or SSA, section 8 vouchers, and client funds. In some cases, state only funds may be used to supplement.)

Neither Service Cost Includes:
*Local law enforcement.
*K-12 education (for those under 22 years of age).
*Cost of DDD case manager or regional administration.
*One-time start up costs (e.g. specialized equipment in either setting, furniture, rental deposit in community-based setting).

Additional Notes:

1) For community-based clients, the cost reflects the average rate budgeted for priority clients by proviso, such as those leaving RHCs, those in crisis, or those in community protection. Individual client costs, based on service needs, can be lower or higher, but this is the average rate the Legislature has budgeted for the last several years. Reports to the Legislature show that actual costs for this proviso population do average about $300/day. Most clients are residing in the Supported Living program.
2) Community-based clients may receive federal-only benefits, similar to SSI, such as food stamps or housing subsidies, as part of their total "service package". These items may have a small state cost to administer them which has not been included.
3) For RHC clients, costs shown are based on actual FY 2004 expenditures averaged over all RHC clients. Individual clients may require service levels that are greater or less than the RHC average, however we cannot determine individual costs for a specific client due to the way RHCs are budgeted.
4) Federal match is assumed at 53%, the enhanced rate for FY 04. Current federal match is around 50%.

EMERGING ISSUES

There were a number of issues that were of interest to the Council, including, cross-state comparison data, client acuity levels, demographic trends, and prioritization criteria for future funding. However, due to time constraints, only the following emerging issues were briefly introduced at the third Council meeting:

Aging Clients and Aging Caregivers

The system of residential services relies on families to care for individuals with developmental disabilities. Statewide, there are 1,374 adults on the state DDD caseload who are age 40 years or older who live with their parents or a relative. According to a 1997 statewide survey by the University of Washington Center for Disability Policy and Research, 44% of parents over 60 years of age who have a child with developmental disabilities, are still serving as full time caregivers. Life expectancy of people with developmental disabilities is much longer than it used to be, and, as they age, client residential needs change. Life expectancy for caregivers is also much longer, and as they age their needs will also change. Questions to consider:

- What kind of analysis, projected over the next twenty years, should be done to estimate the growth and needs of both aging clients and aging caregivers?
- How many will need out of home residential and other services?

Respite Care Services

Respite care is a temporary residential service provided to a person and/or the person's family on either a planned or an emergency basis. Respite care may be provided in a person's own home, out-of-home in a licensed community home or facility, or at an RHC. Length of time is based on needs as determined in the person's individual service plan. Planned respite is typically used for family breaks or planned medical care for family members, for conducting assessments of the person, or waiting for a community placement. Crisis respite is offered at the RHCs depending on space available at the time of the emergency. There are 26 beds funded at the RHCs for respite care, although the actual number may vary according to individual circumstances at the RHC. Questions to consider:

- Are respite resources available when and where needed?
- Does crisis respite interfere with planned respite stays?

DDD Supported Living Rates

There are three components to the contracted residential services rate: instruction and support services (staff hours for teaching and assistance to clients), administration, and indirect client supports. The concern of community providers is that supported living rates are not adequate. Questions to consider:

- How do we maintain competitive wage rates in order to attract quality staff and prevent staff turnover?
- Should there be an annual inflationary adjustment that recognizes increasing operational costs?

PART III: COUNCIL DISCUSSION

The Council met three times and although discussion time was limited by the amount of data and background that needed to be covered, members engaged in several brainstorming sessions as they began to think about what a preferred residential system might look like. (Note: brainstorming does not indicate consensus.)

RESIDENTIAL SERVICES FRAMEWORK

The Council brainstormed a framework for a "vision" of residential services. (See meeting notes on the website for November 18, 2005.) Individuals with developmental disabilities rely on the state-funded DDD system of residential services for many things beyond the basics of a "roof over their heads" and safety and health. They also rely on residential services for:

1. Experience making personal choices, including the kind of choices that living in the community offers
2. Learning and independence
3. Supervision
4. Integration and community access
5. Continuing (in the community model) of the home environment they may have experienced with their families
6. Continuity and stability
7. Employment
8. Adaptive equipment
9. Communication—particularly for people who are not verbal, staff can communicate their needs
10. Help with planning for the future

The Council brainstormed the following criteria for evaluating an effective system of residential services. Ideally, to be effective, residential services for individuals with developmental disabilities would:

1. Be flexible to meet people's needs in the most integrative setting
2. Include options/choices
3. Provide a continuum of care
4. Provide stability in care from birth to death
5. Be available to individuals in their home community where they have developed natural supports
6. Provide a living wage and consistency for the providers themselves
7. Have a system of checks and balances so people won't fall through the cracks
8. Provide quality assurance
9. Be balanced with protections but not too much red tape
10. Include adequate funding

SYSTEM STRENGTHS AND WEAKNESSES

At the December 15, 2005 meeting, the Council brainstormed an analysis of the strengths and weaknesses of a list of components of the current residential system. (See December 15, 2005 Meeting Notes on the website for complete details of the discussion.) Once again, this was a facilitated brainstorming discussion, not fact finding. Individual Council members observed the following:

Greatest Strengths:

- We have a good continuum of care in the state, with a range of services.
- Our families are the backbone of our system.
- We have a community-based system that includes such things as; community based waivers, and the SOLA programs, and Medicaid personal care.
- There is increased recognition of the value of training and providing a living wage.

Greatest Weaknesses and Challenges:

- The system is under-funded and there is limited access to services.
- Some of the choices in the spectrum do involve the giving up of personal liberty.
- There is a potential for abuse and neglect across settings.
- Our state has not dealt with the issue of aging caregivers.
- There is a distinct division within the developmental disabilities community as to which way we should go; we haven't gotten past the community vs. RHC divide.
- We have seen a decrease in the population of the RHCs corresponding with the national trend. Why are we perpetuating the current system and not observing the trend across the nation to change the model of service delivery?

KEY QUESTIONS FOR STUDY

Given the informal criteria for an effective residential system and the brainstormed strengths and weaknesses of the current system, the Council discussed a number of key questions that could serve as a focus for the next phase of work if the Council should be extended. These questions were also part of a facilitated brainstorming exercise and were not refined or narrowed down to an agreed upon list due to lack of time. These notes are quoted verbatim from the meeting; however, they have been grouped by theme.

Lack of Resources, Pressures & Demands

1. Equity issues with non state employee providers; there needs to be equity with the state employees (bring everyone else up)
2. Can people working in the community have the same wages and benefit packages as state employees?
3. Some people get a "ton of services" and some don't get any
4. How do we plan for the future—we must see what will be best in the future—how do we help families plan? What options will be available?

5. Planning for the future—perhaps the future solution should be community-based

Role of the RHCS in Today's System of Services

1. What do people really need? Can we get beyond the schism between the community and the RHCs?
2. There are diverse attitudes, so we should offer choice and continuum of care, but do we really need 5 RHC's?
3. State employees as an issue—not sure how we address this. If we downsize, is it possible to move them into a community setting?
4. We need to talk about how many RHC's we need to have—we have delayed in investing capital funds in those campuses; what are our thoughts on all of the capital funds that are needed?
5. Is there a middle ground here? Is there room for the RHC's to be downsized (e.g. the number of them) but enhance the services they provide and still get more money in the system for those underserved in the community?

System Concerns

1. Power and Choice—do individuals have the right to say where they'd like to live?
2. Will our solution add or detract from lawsuits?
3. Too often big decisions are emotion and not data-driven and it would serve the overall community in the long term to know what are the real facts
4. What best practices are out there across the nation?
5. Can we focus less on one residential option and more on what is needed for the overall system?

DISCUSSION

Some council members are concerned that "this discussion has gone on forever". For some it is a "civil rights issue, not a cost issue". For others it is a matter of "coming together and making some hard choices and recommendations". The following ideas were offered in the December 15, 2005 meeting discussion both as commentary and potential next steps for the work of the Council:

General Comments:

- The Council hasn't had enough time to clarify and discuss the information; too often this is posed as a money issue, but it is also an ideological issue that has evolved over time.
- Can we close even one institution since there are so many unserved?
- There is a fear of the "domino effect", if even one is closed.
- I'm ready to make a decision and put cost off to the side.
- I don't have the luxury of putting costs off to the side—I'm with the majority party.
- Many feel this is a civil rights issue, not a cost issue; it doesn't matter whether community services are more costly if they give greater ability for individuals to rise to their potential; we need to come to a fusion of the virtues of community placement and the virtues of institutions and come to a conclusion that isn't just money-based.

- Don't want consequences like have happened with mental health.
- I hope that we can infuse money into the system.
- We need to come together and make some hard choices and recommendations—this has already been put off too much and we've had public input on all of this—do we really need five Institutions?
- We have to remember that we need to decide what is the best way to serve those we are serving right now—that is the Proviso we're working under right now.
- People need to understand that unspent capital dollars don't automatically translate into operating dollars for the community.
- Concerned about doing a report to the Legislature that doesn't specifically state what the Council could do in the next year that would move this debate further along.
- We've only had 3 meetings and that isn't enough time to make decisions. Obviously, we had a late start.
- It may be impossible to take the issue of capital budgets out of this discussion.
- Information is lacking on acuity. This is not about "robbing Peter to pay Paul".
- What do we hope to gain from acuity testing to help us make a decision?
- Does something have to go the Legislature in January? Need to make it clear that these are discussions, not decisions.
- We haven't come to any decisions. Our January report should review progress but we're not at the point of making recommendations
- What is the role and what are the priorities of government? DDD is one of the core obligations of government.
- The Council needs a work plan to move the debate forward.
- We need a framework in the Proviso. We need a bigger "pie".

Possible Action Steps:

- We have a certain amount of resources. We do have some (proviso) funding left that we could use for a study.
- I'd like an independent study to look at options for leasing, moving or renting state space (e.g. University of WA study)
- What happened in those other states where they did close down the RHC's? What happened to the residents?
- Need to look at other states where they've kept the RHC's and expanded services.
- Ask the two main clusters of interest groups, those who want all services in the community and those who want to see no closures in the RHC's, to get together over the session and come back in April with what they'd like to see done. What if we were to have an agreement or procedural mechanism that we will actually pick one of those choices as the basis for some further recommendation to the Governor?
- We must extend (amend) the Proviso so that all those with needs are served, including those totally unserved.

- We need facilitated discussions outside of the session and that might present a more constructive starting point for us after session.
- Part of the dilemma is that this discussion has gone on forever. If we go back to the stakeholder meetings previously—perhaps we need a framework in the Proviso that directly addresses constraints because of a lack of funding.
- Recommend we extend the work of the Council; that we intend to have a meeting after session, and that we in the interim will look at coming up with more concrete recommendations based on what we learned over the past few months.
- Recommend that there be conversations outside this room and constructive dialogue outside of these meetings. I'd like to see some recommendations put forth as our meetings have focused on information gathering. We still lack information as to the relative acuity. We have some measurements of cost, but we can question some of those cost comparisons. We need acuity measures—perhaps have a study to gain that information. I'd also like us to take the issue of capital budget for RHC's off the table. At best what we can do with those capital budget moneys is to build part of a high school or a new prison. We need to debate about operating budget costs, not capital—but we should stick to debating how to best serve the people in our communities
- I'd like us to utilize Council staff time and to have focus groups and find out what people in the community really want
- The real issues are philosophical. If we're going to talk about what's best for people with developmental disabilities, perhaps a worthwhile thing we can do is to bring studies to the table to look at the value of community inclusion and various options. I've received much updated information from these meetings; but let's look at the best practices around the nation and use that to make our decisions
- Could there be facilitated discussion during session?
- Can we get someone to look at RHC properties for income possibilities?
- Engage professional negotiators to help move forward.

RECOMMENDATION

The Council was appointed in September 2005 and met three times between October and December of 2005. The Council completed the initial phase of data and information gathering, but did not have time to begin the solutions phase of the Study. Although no conclusions or decisions were made in the limited time that was available, the Council informally agreed to recommend that:

- The Developmental Disabilities Residential Study should be extended into 2006 and resume meeting in April 2006 to complete the study and work of identifying a preferred system of residential services.

APPENDIX

Council Membership and Staff List

Fiscal Year 04 Cost Comparison Summary for DD Residential Services

Cost Details and Federal Reimbursement

Residential Study Advisory Council Membership

Dale Brandland, Bellingham	Senator (R-42nd District)
Adam Kline, Seattle	Senator (D-37th District)
Jan Shabro, Enumclaw	Representative (R-31st District)
Brendan Williams, Olympia	Representative (D-22nd District)
Kari Burrell, Seattle	Governor's Executive Policy Office
Dale Colin, Edgewood	Developmental Disabilities Consumer
Greg Devereux, Shelton	Washington Federation of State Employees
Lori Flood, Bothell	Developmental Disabilities Council
Marcy Johnsen, Seattle	Service Employees International Union, Local 1199
Kathy Leitch, Olympia	Department of Social and Health Services
John Mahaney, Yakima	Parent of Individual Receiving RHC Services
Lance Morehouse, Spokane	Parent of Individual Receiving Community Services
Karen Ritter, Seattle	Community Residential Care Provider

Staff

Jonnel Anderson	Senate Republican Caucus
Chelsea Buchanan	Senate Ways and Means
Don Clintsman	Department of Social and Health Services
Amy Hanson	House Appropriations
Sydney Forrester	House Children & Family Services
Gaye Jensen	Governor's Executive Policy Office
Tom Lineham	Office of Financial Management
Yona Makowski	House Democratic Caucus
Kathy Marshall	Department of Social and Health Services
Steve Masse	Office of Financial Management
Donna Patrick	Developmental Disabilities Council
Sharon Swanson	Senate Health & Long-Term Care
Marge Mohoric	Facilitator, Paragon Consulting Group

FY 04 Cost Comparison Summary for Developmental Disabilities Residential Services

Office of Financial Management, Legislative, and DSHS Fiscal Staff Estimates

Community-Based, Budgeted Rate FY 2004 Budget Proviso Level and Estimated Actuals	Daily Costs Total	 State
Residential and Support Services	$ 300	$ 141
Priority Placements (paid through DDD)		
Est. Medical Assistance (paid through MAA)	$ 21	$ 10
Est. Mental Health (paid through MHD)	$ 5	$ 2
Est. Room and Board (SSI, Client Funds)	$ 19	$ -
Total	**$ 345**	**$ 153**
Annual Total	**$ 126,000**	**$ 56,000**

Residential Habilitation Center FY 2004 Average Actual	Daily Costs Total	 State
Operating Costs (Includes IMR tax)	$ 402	$ 189
Less IMR tax	$ (20)	$ (9)
Indirect Costs	$ 21	$ 10
Accrued Vacation Liability	$ (0)	$ (0)
Equipment Depreciation	$ 1	$ 0
Building Depreciation	$ 15	$ 7
Non-Capitalized Bldg Expenditures	$ 0	$ 0
Bond Interest for Bldg	$ 5	$ 2
Less Unallowable Costs	$ (4)	$ (2)
Total	**$ 419**	**$ 197**
Less Client Participation (SSA)	$ (18)	$ (8)
Adjusted Total	**$ 401**	**$ 189**
Annual	**$ 147,000**	**$ 69,000**

Both Service Costs Include:
*Residential supports, which could include 24/7 available supervision.
*Habilitative programming.
*Employment and day.
*Medical, mental health, and therapies (except off-campus hospitalization and some equipment for RHC clients).
*Room and board. (In community-based, room and board is paid with federal SSI or SSA, section 8 vouchers, and client funds. In some cases, state only funds may be used to supplement.)

Neither Service Cost Includes:
*Local law enforcement.
*K-12 education (for those under 22 years of age).
*Cost of DDD case manager or regional administration.
*One-time start up costs (e.g. specialized equipment in either setting, furniture, rental deposit in community-based setting).

Additional Notes:

1) For community-based clients, the cost reflects the average rate budgeted for priority clients by proviso, such as those leaving RHCs, those in crisis, or those in community protection. Individual client costs, based on service needs, can be lower or higher, but this is the average rate the Legislature has budgeted for the last several years. Reports to the Legislature show that actual costs for this proviso population do average about $300/day. Most clients are residing in the Supported Living program.
2) Community-based clients may receive federal-only benefits, similar to SSI, such as food stamps or housing subsidies, as part of their total "service package". These items may have a small state cost to administer them which has not been included.
3) For RHC clients, costs shown are based on actual FY 2004 expenditures averaged over all RHC clients. Individual clients may require service levels that are greater or less than the RHC average, however we cannot determine individual costs for a specific client due to the way RHCs are budgeted.
4) Federal match is assumed at 53%, the enhanced rate for FY 04. Current federal match is around 50%.

RESIDENTIAL HABILITATION CENTERS (RHCs)
FISCAL YEAR 2004
COST DETAILS AND FEDERAL REIMBURSEMENT

		Fircrest ICF/MR	Fircrest N/F	Rainier ICF/MR	Lakeland ICF/MR	Lakeland N/F	Yakima N/F	Morgan ICF/MR	Total	Avg Cost Per Res. Day
	Resident Days	50,327	38,339	140,042	69,378	21,359	38,740	19,487	377,672	
1	**Resident Count**	**138**	**105**	**383**	**190**	**58**	**106**	**53**	**1,033**	
2	Operating Costs (detail next page)	$22,886,475	$14,488,211	$50,903,772	$26,802,571	$6,972,539	$15,248,821	$7,086,887	$144,389,276	$382.31
3	IMR Tax	$1,577,624	$0	$3,708,268	$1,798,141	$0	$0	$508,998	$7,593,031	$20.10
4	**Total Operating Costs**	**$24,464,099**	**$14,488,211**	**$54,612,040**	**$28,600,712**	**$6,972,539**	**$15,248,821**	**$7,595,885**	**$151,982,307**	**$402.42**
5	RHC Dept. Indirect Costs	$1,136,255	$857,174	$2,825,869	$1,383,202	$420,661	$807,957	$386,381	$7,817,499	$20.70
6	RHC Accrued Vacation Liability	($81,564)	($61,531)	$44,185	($31,578)	($9,604)	$7,366	$7,711	($125,015)	($0.33)
7	RHC Equipment Depreciation	$26,612	$20,075	$146,144	$17,422	$5,298	$31,679	$17,936	$265,166	$0.70
8	RHC Building Depreciation	$651,243	$491,289	$1,811,770	$1,090,283	$358,360	$668,543	$409,131	$5,480,619	$14.51
9	RHC Non-Capitalized Bldg Exp	$5,912	$4,460	$43,848	$7,671	$2,522	$2,150	$6,729	$73,292	$0.19
10	RHC Bond Interest for Bldg/Imp	$311,011	$234,622	$545,898	$323,479	$99,898	$220,246	$205,250	$1,940,404	$5.14
11	**Total Other RHC Costs**	**$2,049,469**	**$1,546,089**	**$5,417,714**	**$2,790,479**	**$877,135**	**$1,737,941**	**$1,033,138**	**$15,451,965**	**$40.91**
12	Less Unallowable Costs	($434,308)	($334,360)	($309,963)	($188,188)	($30,858)	($146,469)	($19,341)	($1,463,487)	($3.88)
13	**Total Reimbursable Costs**	**$26,079,260**	**$15,699,940**	**$59,719,791**	**$31,203,003**	**$7,818,816**	**$16,840,293**	**$8,609,682**	**$165,970,785**	**$439.46**
14	**Cost Per Resident Day**	$518.20	$409.50	$426.44	$449.75	$366.07	$434.70	$441.82	$439.46	
15	Less Resident Participation	($902,054)	($590,567)	($2,978,249)	($1,318,988)	($314,101)	($548,685)	($138,900)	($6,791,544)	($17.98)
16	Net Fed. Claim. Amount (Item 13 less Item 15)	$25,177,206	$15,109,373	$56,741,542	$29,884,015	$7,504,715	$16,291,608	$8,470,782	$159,179,241	
16a	Item 14 Less Item 15	$500.27	$394.10	$405.18	$430.74	$351.36	$420.54	$434.69	$421.47	$421.47
17	Federal Reimb. - Total	$13,213,748	$7,928,118	$29,824,177	$15,725,486	$3,942,040	$8,535,919	$4,454,872	$83,624,360	
18	Federal Reimb. - DDD Program	$12,490,956	$7,494,450	$28,192,795	$14,865,302	$3,726,410	$8,069,004	$4,211,191	$79,050,108	
	Item 16a Less IMR Tax	**$468.92**	**$394.10**	**$378.70**	**$404.82**	**$351.36**	**$420.54**	**$408.57**	**$401.37**	**$401.37**

Notes: Item # 1 - Resident Count is the average annual client count determined by dividing the total actual resident days by 366 days. (FY 04 was a Leap Year.)

Item # 3 - The IMR Tax is a tax on ICF/MR services at a rate of 6% of the disbursements for operating costs, other RHC costs and the IMR tax itself.

Item # 4 - Total Operating Costs are the disbursements plus liquidations. These are the expenditures appropriated within the DDD program .

Item # 11 - Total Other RHC Costs include expenditures appropriated within other DSHS programs: Indirect Costs in Programs 110 and 145 and Building and Bond Costs in Capital Programs (Program 900). Current year equipment and lease purchase principal costs that are included on line 4 are removed on line 12 as unallowable costs. Equipment depreciation cost is included on line 7.

Item # 12 - Unallowable Costs are costs that are unallowable for federal reimbursement purposes such as lease purchase principal, coffee shops, barber and beauty and chaplain. Also included are building depreciation and bond interest allocated to unallowable/ non-programmatic activities. Current year building and equipment costs are also included here. Equipment and building depreciation costs are included on lines 7 and 8 above.

Item # 14 - Cost Per Resident Day is determined by dividing the Total Reimbursable Costs by the total actual resident days.

Item # 15 - Resident Participation is the SSA income of residents, as the disabled children of parents or relatives that did work and pay SSA taxes. These funds must be used to contribute to the residents' cost of care before computing the federal share.

Item # 17 - The Federal Financial Participation (FFP) Rate is 53.32% from July 1 thru Sept. 30, 2003 and 52.95% from Oct. 1, 2003 thru June. 30, 2004.
The Federal Reimbursement total includes both the regular monthly claims and the year end cost settlement. The Federal Reimbursement does not include outside hospital and outside physician services and some prescribed medical supplies which are paid through Medical Assistance Administration.

Item # 18 - The Federal Reimbursement credited to the DDD program is 94.53 percent of the total. The remainder is under programs 110, 145 and 850.